DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155747	A. BUILDING 00 B. WING	08/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODCREST NURSING CENTER	1300 MERCER AVE DECATUR, IN 46733

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: August 20, 21, 22, 23 and 24, 2012 Facility number: 000556 Provider number: 155747 AIM number: 1002900130 Survey Team: Linn Mackey, RN TC Shelley Reed, RN Karen Lewis, RN Ginger McNamee, RN Census bed type: SNF/NF: 126 Total: 126 Census payor type: Medicare: 14 Medicaid: 75 Other: 37 Total: 126 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 8/30/12 by Suzanne Williams, RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to ensure the physician was notified promptly for having brown emesis for 1 of 10 residents reviewed for unnecessary	F0157	It is the policy of this provider to immediately inform the resident, consult with the resident's physician, and notify the resident's legal representative of a significant change in the	09/15/2012

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	medications. [Resident #18] Findings include: Resident #18's clinical record was reviewed on 8/23/12 at 8:52 a.m. The resident's diagnoses included, but were not limited to, status post small bowel obstruction of the ileus, atrial fibrillation, hypertension, congestive heart failure, and chronic back pain. Review of Resident #18's nursing notes indicated the following: 8/6/12, 6:00 p.m., The resident was vomiting a moderate amount of brown liquid and her 6:00 p.m. medications were held. The resident was given 30 cc of Al-Mag [an antacid]. Her vital signs were obtained at the time. 8/6/12, 8:00 p.m., The resident vomited a moderate amount of brown liquid and her 8:00 p.m. medications were held. 8/6/12, 11:00 p.m., "Dr. called. Res [resident] allergic to Phenergan [for nausea and vomiting]. [Circle with a line through it] [No] other N/V [nausea/vomiting] med [medication] available. Order received to send res to [name of hospital] ER [emergency room.] Daughter notified."		resident's condition. The provider respectfully request IDR of this alleged deficiency. *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:* Resident #18 did not return to the facility, no action is required for this resident. *2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:* Other residents with the propensity to be affected by the alleged deficient practice were identified as those with nausea and vomiting. None were so identified. *3. What measures will be put into place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:* The process of reading all nurses' notes on a daily basis (in place for > one year) by the Unit Managers will continue unchanged. The unit managers will during that review, will monitor any residents identified with nausea and vomiting or possible bowel obstruction. The weekly Resident Care Committee will review 3 charts randomly selected to assess if a patient has nausea and vomiting or a possible bowel obstruction and if affirmed, that physician notification has occurred within a professional standard parameter. If it has not, corrective in-servicing will occur.	

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	8/7/12, 3:30 a.m., Received a call from the emergency room and the resident was being admitted with a possible bowel obstruction and hypokalemia. 8/7/12, late entry for 8/6/12, 11:00 p.m., The resident had vomited a large amount of brown liquid. During an interview with the Director of Nursing on 8/23/12 at 3:30 p.m., she indicated the physician was not notified until 8/6/12 at 11:00 p.m. The policy for "Physician Notification" was requested from the Director of Nursing during the interview. No further information was provided related to the "Physician Notification" policy as of the time of exit 8/24/12 at 12:10 p.m. 3.1-5(a)(2)		A summary of these findings will be forwarded to the DNS or designee to present to PI/QA&A Committee for review, monthly for 3 months and quarterly thereafter. *4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place:* The PI/QA&A Committee will review the summary from above and make recommendations based on the summaries for continued monitoring. *5. Completion date:* September 15, 2012.	

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F0159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that			

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	receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.			
	Based on interview, the facility failed to ensure residents had ready access to their personal account funds managed by the facility for 2 of 5 residents interviewed of the 5 residents that met the criteria for ready access of personal account funds, and potentially affecting all residents who have personal fund accounts with the facility. (Resident #57 and #50) Findings include: 1.) During a resident interview on 8/20/12 at 2:36 p.m., Resident #57 indicated resident personal funds were not accessible on the weekends. 2.) During a resident interview on 8/20/12 at 2:59 p.m., Resident #50 indicated resident personal funds were not accessible on the weekends. 3.) During an interview with the	F0159	It is the policy of this provider to ensure residents have ready access to their personal account funds managed by the facility. The provider respectfully requests IDR of the alleged deficiency. *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:* Resident #57 and Resident #50 were informed of the procedure to obtain funds from their personal accounts on the weekends and after hours. *2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:* Other residents with the propensity to be affected by the alleged deficient practice were identified as those with facility managed personal fund accounts. 52 were so identified. *3. What measures will be put into*	09/15/2012

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	Business Office Manager on 8/22/12 at 11:37 a.m., she indicated the facility did not have banking hours on the weekends. 3.1-6(f)(1)		*place or what systemic changes will be made to ensure that the alleged deficient practice does not recur:* All residents and family members of residents, who have a facility managed personal account, were reminded of the procedure to obtain funds from the business office during the weekends and after hours, while the survey was in progress. All admissions are notified of this policy upon entry into the facility. *4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place:* Through the Guardian Angel Program, all residents will be queried as to the proper procedure to obtain funds from their personal accounts managed by the facility on weekends and after hours. The question will be asked during the Guardian Angel Resident interview. Queuing will be provided to assist in recollection/retention. The results of the interviews for those residents with FMPA's will be reported to the Business Office manager who will report to the QA&A/PI committee monthly for 6 months. It will review and recommend further action as it sees fit.	

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F0241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.			
	Based on interview and record review, the facility failed to ensure the staff treated residents with respect and dignity for 1 of 2 residents reviewed for respect and dignity of 2 residents who met the criteria for dignity. (Resident #139) Findings include: During an interview with Resident #139 on 8/20/12 at 2:15 p.m., the resident indicated not being treated with respect and dignity. The resident indicated staff will sometimes take her to the bathroom to toilet and leave her there for long periods of time. She indicated that she occasionally gets nervous when they do not come back and she will put her call light on and they do not answer for a long time. She indicated her right leg often hurts since she broke her hip and her blood supply is cut off from sitting too long. Resident #139 was unable to identify the staff member or when the incident occurred.	F0241	It is the policy of this provider to provide care for residents in a manner that enhances resident dignity and respect in full recognition of his/her individuality The provider respectfully requests IDR for this alleged deficiency. ***What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?*** Resident #139 was interviewed by facility staff upon notification of this concern. Staff was instructed to give “cares in pairs,” and to document the length of time that the resident is afforded privacy for elimination. The facility was unaware (as documented by the survey findings) of any concerns regarding resident dignity. The resident was reminded to alert staff (Unit manager and Guardian Angel) if this continues to or again becomes an issue in the future. ***How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?*** All residents who have maximum assistance required for	09/15/2012

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	The resident indicated the incident was not reported. Resident #139's clinical record was reviewed on 8/22/12 at 3:17 P.M. Resident #139's diagnoses included, but were not limited to: anxiety, hypertension, weight loss, hypothyroidism, congestive heart failure and right hip fracture. Resident #139 scored a 15 of 15 for the brief interview mental status (BIMS) on the Minimum Data Set assessment (MDS) dated 7/23/12 indicating the resident was reliably interviewable. During the same record review, the scheduled toileting record was reviewed and indicated the resident is toileted every two hours. The MDS dated 7/23/12 indicated the resident required one person staff assistance to move to and from the toilet. She was continent of bowel and incontinent of bladder. The resident had impairment on both upper and lower extremities and required the assistance of a walker for mobility. During an interview with Social Service Assistant #1 on 8/24/12 at 9:19 a.m., she indicated she was		assistance in toileting have the potential to be affected and will be identified during Guardian Angel rounds weekly. The question “Is your call light answered timely?” will be asked and negative responses addressed by the Guardian Angel, on the spot. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** House-wide staff members have received training related to dignity. ***How will the corrective actions be monitored to ensure the deficient practice does not recur?*** Information gathered from the bi-weekly Guardian Angel round audit tools will be summarized and the findings will be forwarded to the DNS or designee to present to PI/QA&A Committee for review, monthly for 3 months and quarterly thereafter. Recommendations from the PI/QA&A committee for changes to monitoring schedule will be forwarded back to the Director of Nursing for implementation ***By what date will the systemic changes be completed?*** September 15, 2012.	

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	unaware of the resident having concerns related to being left on the toilet too long and will follow-up with the resident related to these concerns, as well as the Unit Manager. Review of a current facility policy dated 2/9/00 titled "Resident Rights" which was provided by the Director of Nursing on 8/20/12 at 10:00 a.m., indicated the following: "Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." 3.1-3(t)			

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F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on record review and interview, the facility failed to ensure the nursing staff monitored and documented a resident's fluid intake and dialysis fistula in accordance with his plan of care for 1 of 1 resident reviewed for dialysis. (Resident #5) Findings include: 1.) The clinical record for Resident #5 was reviewed on 8/23/12 at 8:20 a.m. Diagnoses for Resident #5 included, but were not limited to: end-stage renal disease, hypertension, and diabetes mellitus. The resident had a signed 7/2/12, physician's order for a daily 1200 ml (milliliter)fluid restriction. The order was clarified 7/2/12 to be 1500 ml, and initiated on 7/3/12. The resident had a care plan for "At risk for fluid/electrolyte imbalances due to dialysis/renal failure" with interventions of:	F0282	It is the policy of this provider to ensure that the services provided by or arranged by the provider are rendered by qualified personnel and in accordance with the resident's written care plan. ***What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?*** Resident #5 will have the fistula assessed each shift, and the fluid restriction of 1500 ml maintained by record of intake. ***How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?*** Other residents having the propensity to be affected by the alleged deficient practice would be identified as those residents receiving hemodialysis. None were so identified. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** Nursing staff members have received training related to the completion of the intake sheets for residents on hemodialysis. Licensed nursing staff has received training related	09/15/2012

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	a. Fluid restriction of 1500 ml daily b. Measure/record intake and output every shift c. Assess fistula every shift Review of the July intake and output record indicated on the following dates and times Resident #5 did not have intake monitored as ordered: 7/4/12 - no intake recorded for the 3:00 p.m.-11:00 p.m. shift, or daily total 7/7/12 - no intake recorded for the 3:00 p.m.-11:00 p.m. shift, or daily total 7/10/12 - no intake recorded for the 3:00 p.m.-11:00 p.m. shift, or daily total 7/12/12 - no intake recorded for the 3:00 p.m.-11:00 p.m. shift, or daily total 7/13/12 - no intake recorded for the 11:00 p.m. -7:00 a.m. shift, or daily total 7/16/12 - no intake recorded for the 3:00 p.m.-11:00 p.m. shift, or daily total 7/17/12 - no intake recorded for the 3:00 p.m.-11:00 p.m. shift, or daily total 7/30/12 - no intake recorded for the		to the necessity of fistula assessment q shift. ***How will the corrective actions be monitored to ensure the deficient practice does not recur?*** Unit manager will audit the documentation Monday to Friday, to ensure that the resident's care plan as mentioned is being followed. A summary of these findings will be forwarded to the DNS or designee to present to PI/QA&A Committee for review, monthly for 3 months and quarterly thereafter. Recommendations for changes to the monitoring schedule will be forwarded back to the Director of Nursing for implementation. ***By what date will the systemic changes be completed?*** September 15, 2012.	

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	11:00 p.m. -7:00 a.m. shift, or daily total This resulted in the resident not being monitored for the physician ordered daily fluid restriction for 8 of the 29 days reviewed in July 2012. Review of the July nurses notes indicated on the following dates and times Resident #5 had his fistula assessed: 7/3/12 at 2:00 p.m. 7/8/12 at 8:00 p.m. 7/10/12 at 12:00 p.m. 7/24/12 at 6:00 a.m. This resulted in the resident's fistula being assessed 4 out of 87 opportunities. During an interview with RN #1 on 8/23/12 at 9:47 a.m., she indicated the CNAs report the fluid intake for residents to the nurse and the nurse then documents the intake on the Intake and Output record. She also indicated the resident's dialysis access was assessed after dialysis on the post dialysis treatment form, and kept in the Medication Administration Record (MAR). During an interview with the Director			

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	of Nursing on 8/23/12 at 3:42 p.m., additional information was requested related to the monitoring of the fluid restriction and assessment of the dialysis fistula for Resident #5. The facility failed to provide any additional information as of exit on 8/24/12. 2.) Review of the current facility policy, dated 10/11, titled "DIALYSIS/HEMODIALYSIS", left on the table on 8/24/12 at 8:20 a.m., included, but was not limited to, the following: "II. Purpose: Provide appropriate care of resident receiving Dialysis/ Hemodialysis. III. Procedure:... ...Care of fistula as per protocol-monitor (Bruit) each shift...." 3.1-35(g)(2)			

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F0309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on record review and interview, the facility failed to monitor a resident for a bowel obstruction [Resident #18] for 1 of 10 residents reviewed for unnecessary medications. Findings include: Resident #18's clinical record was reviewed on 8/23/12 at 8:52 a.m. The resident's diagnoses included, but were not limited to, status post small bowel obstruction of the ileus, atrial fibrillation, hypertension, congestive heart failure, and chronic back pain. Review of Resident #18's nursing notes indicated the following: 8/6/12, 6:00 p.m., The resident was vomiting a moderate amount of brown liquid and her 6:00 p.m. medications were held. The resident was given 30 cc of Al-Mag [an antacid.] Her vital signs were obtained at the time with no abdominal assessment.	F0309	It is the policy of this provider to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and care plan. The provider respectfully request IDR of this alleged deficiency. *1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice:* Resident #18 did not return to the facility, no action is required for this resident. *2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action will be taken:* Other residents with the propensity to be affected by the alleged deficient practice were identified as those with nausea and vomiting. None were so identified. The unit managers will during daily review, will monitor any residents identified with nausea and vomiting or possible bowel obstruction. *3. What measures will be put into place or*	09/15/2012

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	8/6/12, 8:00 p.m., The resident vomited a moderate amount of brown liquid and her 8:00 p.m. medications were held. No vital signs or abdominal assessment was obtained. 8/6/12, 11:00 p.m., "Dr. called. Res [resident] allergic to Phenergan [for nausea and vomiting.] [Circle with a line through it] [No] other N/V [nausea/vomiting] med [medication] available. Order received to send res to [name of hospital] ER [emergency room.] Daughter notified." 8/7/12, 3:30 a.m., Received a call from the emergency room and the resident was being admitted with a possible bowel obstruction and hypokalemia. 8/7/12, late entry for 8/6/12, 11:00 p.m., The resident had vomited a large amount of brown liquid. No assessment of the abdomen or vital signs were completed. The resident had a 7/23/12, care plan problem of potential for discomfort, complications related to constipation. An approach for the problem included assess/record/report to MD as needed signs and symptoms of constipation/fecal impaction, abdominal pain, abdominal distention,		_what systemic changes will be made to ensure that the alleged deficient practice does not recur:_ The process of reading all nurses' notes on a daily basis (in place for > one year) by the Unit Managers will continue unchanged. The unit managers will during that review, will monitor any residents identified with nausea and vomiting or possible bowel obstruction. The weekly Resident Care Committee will review 3 charts randomly selected to assess if a patient has nausea and vomiting or a possible bowel obstruction and if affirmed, that physician notification has occurred within a professional standard parameter. If it has not, corrective in-servicing will occur. A summary of these findings will be forwarded to the DNS or designee to present to PI/QA&A Committee for review, monthly for 3 months and quarterly thereafter. _4. How the corrective action will be monitored to ensure the deficient practice will not recur i.e. what quality assurance program will be put into place:_ The PI/QA&A Committee will review the summary from above and make recommendations based on the summaries for continued monitoring. _5. Completion date:_ September 15, 2012.	

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	straining at stool, hard stool, nausea/vomiting, fever, and altered mental status. During an interview with the Director of Nursing on 8/23/12 at 3:30 p.m., she indicated she had no further information to provide related to the abdominal assessments and the physician not being notified until 8/6/12 at 11:00 p.m. 3.1-37(a)			

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F0431 SS=B	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
	Based on observation and interview, the facility failed to ensure the tubes and bottles of topical medications were properly labeled with resident	F0431	It is the policy of this provider to ensure tubes and bottles of topical medications are properly stored and labeled. ***<u>What corrective actions will be</u>***	09/15/2012

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	names and physician's name for 3 of 5 treatment carts reviewed, potentially affecting 89 residents living on Peach, Spring and Maple Street Halls of 126 residents in the facility. Findings include: 1. On 8/23/12 at 1:40 p.m., while observing medication storage, tubes of medicated ointments, creams and dry powder were found without labels to identify which resident the medication belonged on treatment carts on Maple, Peach and Spring Street Halls. The treatment cart for Peach Tree Hall contained the following tubes of ointments and creams without resident specific label: Clotrimazole/Betamethasone(topical antifungal) and Nystatin 100,000(topical antifungal). The treatment cart for Spring Street Hall contained the following tubes of topical medicated creams and lotions: Hydrocortisone 2.5%(topical steroid) and Mupirocin 2%(topical antibiotic). The treatment cart for Maple Street Hall contained the following bottle of topical medicated powder; Nystop(topical antifungal).		***accomplished for those residents found to have been affected by the deficient practice?*** The improperly labeled tubes/bottles of topical medication were disposed of and replacements were received. ***How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken?*** Other residents with the propensity to be affected by the same alleged deficient practice would be identified as those residents that have unlabeled topical medications. None were so identified. ***What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?*** Nursing staff members have received in-servicing related to maintaining the boxes which the labels are usually attached to. Nurse managers will audit the carts to ensure that medications are labeled appropriately. A summary of these findings will be forwarded to the DNS or designee to present to PI/QA&A Committee for review, monthly for 3 months and quarterly thereafter. ***How will the corrective actions be monitored to ensure that deficient practice will not recur?*** Information gathered from the audits will be forwarded to the PI/QA&A committee monthly for	

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	Interview on 8/24/12 at 9:55 a.m. with DON indicated the Pharmacy Consultant reviews and checks the medication and treatment carts monthly and were last checked on 7/19/12. 3.1-25(j) 3.1-25(k)		inclusion, review and recommendation for further monitoring. ***What date will the systemic changes be completed?*** September 15, 2012	

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
	Based on record review and interview, the facility failed to ensure resident clinical records were complete and accurately documented for 1 of 10 residents reviewed for complete and accurate clinical records. (Resident #5) Findings include: 1.) The clinical record for Resident #5 was reviewed on 8/23/12 at 8:20 a.m. Diagnoses for Resident #5 included, but were not limited to: end-stage renal disease, hypertension, and diabetes mellitus. The resident had a signed 7/2/12, physician's order for a daily 1200 ml	F0514	It is the policy of this provider to ensure that the resident clinical records are complete and accurately documented. ***What corrective actions will be accomplished for those residents found to have been affected by the deficient practice?*** Resident #5 will have the fistula assessed each shift, and the fluid restriction of 1500 ml maintained by record of intake. ***How will other residents having the potential to be affected by the same deficient practice be identified and what corrective actions will be taken?*** Other residents having the propensity to be affected by the alleged deficient practice would be identified as those residents receiving hemodialysis. None were so identified. ***What measures will be put into place or what systemic changes will***	09/15/2012

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	(milliliter) fluid restriction. The order was clarified 7/2/12 to be 1500 ml, and initiated on 7/3/12. Review of the July intake and output record indicated on the following dates and times Resident #5 did not have intake monitored as ordered: 7/4/12 - no intake recorded for the 3:00 p.m.-11:00 p.m. shift, or daily total 7/7/12 - no intake recorded for the 3:00 p.m.-11:00 p.m. shift, or daily total 7/10/12 - no intake recorded for the 3:00 p.m.-11:00 p.m. shift, or daily total 7/12/12 - no intake recorded for the 3:00 p.m.-11:00 p.m. shift, or daily total 7/13/12 - no intake recorded for the 11:00 p.m. -7:00 a.m. shift, or daily total 7/16/12 - no intake recorded for the 3:00 p.m.-11:00 p.m. shift, or daily total 7/17/12 - no intake recorded for the 3:00 p.m.-11:00 p.m. shift, or daily total 7/30/12 - no intake recorded for the 11:00 p.m. -7:00 a.m. shift, or daily total This resulted in the resident not being		***be made to ensure that the deficient practice does not recur?*** Nursing staff members have received training related to the completion of the intake sheets for residents on hemodialysis. Licensed nursing staff has received training related to the necessity of fistula assessment q shift. ***How will the corrective actions be monitored to ensure the deficient practice does not recur?*** Unit manager will audit the documentation Monday to Friday, to ensure that the resident's care plan (fistula assessment and fluid intake) as mentioned is being followed. A summary of these findings will be forwarded to the DNS or designee to present to PI/QA&A Committee for review, monthly for 3 months and quarterly thereafter. Recommendations from the PI/QA&A committee for changes to monitoring schedule will be forwarded back to the Director of Nursing for implementation. ***By what date will the systemic changes be completed?*** September 15, 2012	

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monitored for the physician ordered daily fluid restriction for 8 of the 29 days reviewed in July 2012.

The resident had a care plan for "at risk for fluid/electrolyte imbalances due to dialysis/renal failure" with interventions of: Assess fistula every shift.

Review of the July nurses notes indicated on the following dates and times Resident #5 had his fistula assessed:

7/3/12 at 2:00 p.m.
7/8/12 at 8:00 p.m.
7/10/12 at 12:00 p.m.
7/24/12 at 6:00 a.m.

This resulted in the resident's fistula being assessed 4 out of 87 opportunities.

During an interview with RN #1 on 8/23/12 at 9:47 a.m., she indicated the CNAs report the fluid intake for residents to the nurse and the nurse then documents the intake on the Intake and Output record. She also indicated the resident's dialysis access was assessed after dialysis on the post dialysis treatment form, and kept in the Medication Administration Record (MAR).

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	During an interview with the Director of Nursing on 8/23/12 at 3:42 p.m., additional information was requested related to the monitoring of the fluid restriction and assessment of the dialysis fistula for Resident #5. The facility failed to provide any additional information as of exit on 8/24/12. 3.1-50(a)(1) 3.1-50(a)(2)			